Obstacles in seeking a legal reaction on violent incidents in psychiatry

Harte, J.M.; van Houwelingen, I.; van Leeuwen, M.E.

published in
Proceedings of the 10th European Congress on Violence in Clinical Psychiatry.
2017

Obstacles in seeking a legal reaction on violent incidents in psychiatry

Paper

Joke Harte, Ingrid van Houwelingen & Mirjam van Leeuwen (Netherlands)

Keywords: Legal reaction, reporting to police, criminal law

Background

Compared to other professionals, caretakers in psychiatry encounter a lot of aggressive incidents that can have severe and far reaching consequences (Richter & Berger, 2006; Foster, Bowers & Nijman, 2007; Anderson & Wets, 2011; Van Leeuwen & Harte, 2015; Van Zwieten et al, 2015; Evers, Jettinghoff & Van Essen. 2015). In society, reporting violent incidents to the police is an acceptable reaction. However, mental health professionals who are victimized by an assault caused by a patient appear to be reluctant to seek a legal reaction, even if the incident resulted in severe injuries. This is also the case if there seems to be no relation between the patient's disorder and his aggressiveness.

In general, a criminal procedure starts with the victim who reports the delinquent act to the police (Wittebrood, 2006). Not reporting serious violence, that takes place within a psychiatric hospital, to the police might result in legal inequality and dangerous situations for mental health care workers, other patients and, ultimately, for society. In this study we examined the literature on the needs of mental health care workers after being victimized. We investigated what victims, who decide to report an incident to the police, hope to achieve. Subsequently, the obstacles and dilemma's victims encounter when they consider reporting an aggressive incident to the police were investigated and described.

Literature

Examination of the literature reveals that victims of violence on the psychiatric ward are in need of support, recognition from colleagues, employers and, when seeking legal support, recognition from the police and the public prosecutor (Ten Boom& Kuijpers, 2012; Wikman, 2014). Additionally, they are in need of information and legal advice (Goudriaan, Nieuwbeerta & Wittebrood, 2005). The main reasons for victims to report an incident to the police are mostly rational (Harte, Van Leeuwen & Theuws, 2013). They aim to set a limit to the perpetrators behaviour, to build a file on a patient who is repeatedly violent, and to protect other colleagues and other patients. It appears that victimized care workers do not aim retaliation, especially if the perpetrator did not act on purpose (Darley & Pittman, 2033; Sitka & Houston, 2001).

When mental health care workers consider to report an incident to the police, there appears to be severe obstacles and dilemma's (Dinwiddie & Briska, 2004; Van Leeuwen & Harte, 2011; Wilson e.a. 2012; Clark e.a. 2012; Knoth & Ruback, 2016): 1) the patient's possible diminished criminal responsibility, 2) the fear to break the professional confidentially, 3) the fear of retaliation by the patient or the patient's network, 4) the fear to disturb the therapeutic relationship, 5) the idea that reporting violence caused by a psychiatric patient is not a legitimate response. Moreover, 6) victims who do report the incident to the police are informed poorly by their case.

Method

Empirical data were collected on the obstacles victims face when seeking a legal reaction on violent incidents in psychiatry. First, national as well as local policy documents and covenants between the

police and mental health care institutions, with regard to violence in psychiatry were gathered and scrutinized to find out to what extent the before mentioned obstacles and dilemmas are addressed. Second, an inventory questionnaire was sent to lawyers working in intramural psychiatry and filled-in and returned by 23 of them. Third, a total of 34 in-depth interviews were conducted with stakeholders and experts. Participants were 13 mental health care workers who had been victimized by violence caused by a patient and who had reported this to the police, 10 persons working as a manager in a mental health care institute, 6 police officers, 3 public prosecutors, 1 barrister and 1 judge.

Preliminairy results

We gathered and aggregated all respondents experiences with regard to the barriers and dilemma's that had emerged from the literature:

1) diminished criminal responsibility
How victims perceive the violence they encounter largely depends on whether or not the patient intended to hurt them. In general, if the violence derives from the patient's psychopathology, victims argue that a judicial reaction does not make any sense as the patient cannot be held responsible for his behaviour. But, if the patient forms a serious threat to his environment as a consequence of a severe psychiatric disorder, a court's decision might be necessary to have the patient transferred to a high security hospital. To prosecute a case, assessment of the patient's criminal responsibility is needed. Therefore, the public prosecutor often demands information on the psychiatric condition of the assailant, whereas the employee is not able and not allowed to provide such information.

2) fear to break the professional confidentially
In the Netherlands, the regulations on professional confidentially are complicated, difficult to apply in real-life situations and very strict. Policy documents and covenants provide contradictory instructions on which information is allowed to be communicated to the police and the public prosecutor. As the legal consequences can be far-reaching, mental health care workers who consider reporting a violent incident to the police are afraid to break the rules of professional confidentiality. As a consequence, they choose to refrain from providing any information. In practice, police officers and public prosecutors, not acquainted with the strict regulations, can react annoyed when confronted with the victim's reluctance to provide any information on the perpetrator.

3) fear of retaliation
Victims regularly decide not to report an incident to the police as they fear retaliation by the patient or the patient's network. There are some procedures to conceal the victims identity. However, anonymity cannot be guaranteed when the case is brought to court. Moreover, the perpetrator most often knows who has been victimized. Some employers choose to report the violence that has been committed against their employees. However, according to some police officers and the public prosecutors a victim's own testimony is necessary to make a case.

4) fear to disturb the therapeutic relationship
As treatment in clinical psychiatry is often involuntary, care needs to be continued, even after a violent incidence. In practice it appears to be very difficult to have a patient who has been violent transferred to another institute. As a consequence, the victimized and sometimes traumatized mental health care worker is forced to continue providing care to the perpetrator. Being afraid to disturb the therapeutic relationship, caretakers sometimes decide not to take any legal steps.

5) reporting violence in psychiatry is not a legitimate response
Almost all interviewed respondents consider violence in psychiatry to a certain extent as an occupational hazard. It is, however, unclear in which cases a judicial reaction might be a legitimate response. Was the incident serious enough? Was it the patients intention to hurt the care taker? Was the victim, to a certain extent, self to blame? In most psychiatric institutions consensus on in which cases a legal reaction is

suitable, or even necessary, is lacking. Victims are regularly advised by colleagues and managers not to seek legal action by stating that violence is part of their job.

6) victims are informed poorly by their case
For most victims it is important to be informed about their case and the decisions made by the public prosecutor. The stakeholders have acknowledged that informing the victims is relevant as covenants and policy documents include agreements on this topic. In practice, however, victims seldom receive any information on, for example, the fact that the case was dismissed by the public prosecutor.

Conclusion

Violence against mental health care workers is a substantial and serious problem. To a certain extent, violence caused by patients is part of the job. Even with strong preventive measures, it won't be possible to prevent all aggressive incidents. It is, however, of great importance to support mental health care workers who encounter violence by patients and inform them on the possibility to report a violent incident to the police.
Our results show that in psychiatry there is a lack of consensus on in which cases reporting violence to the police is an appropriate response to inpatient violence. There also appears to be a lack of clarity about in which cases the professional confidentially might be broken, and if so, which information can and cannot be shared with the police and public prosecutor.

The police and public prosecutor should acknowledge the amount and severity of violence that mental health care workers encounter while doing their work. They should also realize that victims who seek legal measures mainly have rational motives; they do not aim any retaliation but want to prevent future violence. Moreover, police officers and public prosecutors should be aware of the limitations health care workers have to deal with when reporting a violent act, as a consequence of their professional confidentially, and their possible fear for retaliation by the patient or the patients network.

Violence in psychiatry is a complex and substantial problem. In the majority of the cases, prosecution is certainly not a suitable reaction. However, in some cases a judicial reaction might be necessary, for example to continue the treatment of a serious aggressive psychiatric patient in a high security hospital. A judicial reaction starts with the victim who reports an incident to the police. It is the responsibility of all stakeholders to jointly tackle the barriers and complications victims face when they consider to report the violent acts to the police.

Acknowledgements

We thank research program Politie & Wetenschap for their financial support in carrying out this research.

References

Anderson, A. & Wets, S.G. (2011). Violence Against Mental Health Professionals: When the Treater Becomes the Victim. *Innovations in Clinical Neuroscience,* 8, 34-39.
Clark, C., Christopher, R.C., Bernadette, A.M. & Ian, B. (2012). The prosecution of psychiatric inpatients: overcoming the barriers. *The Journal of Forensic Psychiatry & Psychology,* 23(3), 371-381.
Darley, J.M. & Pittman, T.S. (2003). The Psychology of Compensatory and Retributive Justice. *Personality and Social Psychology Review,* 7, 324-336.
Dinwiddie, S. & Briska, W. (2004). Prosecution of violent psychiatric inpatients: Theoretical and practical issues. *International Journal of Law and Psychiatry,* 27, 17-29.
Evers, G., Jettinghoff, K. & Van Essen, G. (2015). *AZW Onderzoeksprogramma Arbeidsmarkt Zorg en Welzijn.* Werknemersenquête Zorg en WJK 2015. CAOP, Den Haag.
Foster, C., Bowers, L. & Nijman, H. (2007). Aggressive behaviour on an acute psychiatric wards: prevalence, sererity and management. *Journal of Advanced Nursing,* 58, 140-149.
Goudriaan, H., Nieuwbeerta, P., & Wittebrood, K. (2005).Overzicht van onderzoek naar determinanten van aangifte doen bij de politie. *Tijdschrift voor Veiligheid en Veiligheidszorg,* 4(1), 27-48.

Harte, J.M., Leeuwen, M.E. van & Theuws, R. (2013). Agressie en geweld tegen hulpverleners in de psychiatrie; aard, omvang en strafrechtelijke reactie. *Tijdschrift voor Psychiatrie,* 55(5), 325-33.
Knoth, L.K. & Ruback, B. (2016). Reporting Crimes to the Police Depends on Relationship Networks: Effects of Ties Among Victims, Advisors, and Offenders. *Journal of Interpersonal Violence,* 1-25.
Richter, D. & Berger, K. (2006). Post-traumatic stress disorder following patient assaults among staff members of mental health hospitals: a prospective longitudinal study. *BMC Psychiatry,* 6:15.
Sitka, L.J. & Houston, D.A. (2001). When due process is of no consequence: moral mandates and presumed defendant guilt or innocence. *Social Justice Research,* 3, 305-326.
Ten Boom, A. & Kuijpers, K. F. (2012). Victims' needs as basic human needs. *International Review of Victimology,* 18, 155-179.
Van Leeuwen, M.E. & Harte, J. M. (2011). Violence against care workers in psychiatry; is prosecution justified? *International Journal of Law and Psychiatry,* 34, 317-323.
Van Leeuwen, M.E. & Harte, J. M. (2015). Violence against mental health care professionals: prevalence, nature and consequences. *The Journal of Forensic Psychiatry & Psychology,* 1-18.
Van Zwieten, M., Vroome, E. de, & Bossche, S., van den. (2015). *Monitor Veilige Publieke Taak 2015.* Rapportage voor Ministerie van Binnenlandse Zaken en Koninkrijksrelaties. Programma Veilige Publieke Taak. Leiden: TNO
Wikman, S. (2014). Threats and violence in the Care Sector: Proposed Safety Measures in Swedish Occupational Injury Reports 1987, 1997 and 2007. *International Criminal Justice Review,* 24(2), 172-193.
Wilson, S., Murray, K., Harris, M. & Brown, M. (2012). Psychiatric in-patients, violence and the criminal justice system. *The Psychiatrist,* 36, 41-44.
Wittebrood, K. (2006). *Slachtoffers van criminaliteit: Feiten en achtergronden.* Den Haag: Sociaal en Cultureel Planbureau.

Correspondence

Joke M. Harte
Vrije Universiteit Amsterdam
Department of Criminal Law and Criminology
De Boelelaan 1105
1081 HV Amsterdam
The Netherlands
j.harte@vu.nl